# Competition and Markets Authority working paper on analysis of local competition

1. We understand that the CMA has chosen to analyse local competition as a result of the acceleration in acquisitions and consolidation through the 2010s, with large corporate groups now owning around 60% of First Opinion Practices (FOPs) in the UK. The assertion is that this change in market structure has led to an increase in the degree of local concentration in the UK, with concerns raised by some parties during the CMA's consultation on a market investigation reference that there is now an insufficient number of competitors in some areas.

2. We have previously stated that the factors which animal owners take into consideration when choosing a vet surgery for their pet will vary depending on individual circumstances, with proximity and accessibility likely to be key.[1] We therefore fully recognise the CMA's assessment that a customer's choice of veterinary practice will usually be limited to those located within the geographic area where the customer is willing and able to travel.

3. We welcome the CMA's analysis which has found that the supply of FOPs is not generally concentrated, with 85% of FOPs competing with at least three local rivals. In fact, there are only 49 FOP sites identified by the CMA which may not face competition from any other local providers, accounting for only 1% of total sites. Those sites with no competition probably exist in areas where there is insufficient caseload for multiple businesses to exist.

## Further analysis of FOP concentration

4. We note that the strength of competitive constraint imposed on each focal area has been calculated using metrics relating to the services provided and capacity of each site, including: opening hours, the number of consulting rooms, operating theatres, number of Full Time Equivalent (FTE) vets, veterinary services provided at the site, and type of in-clinic diagnostic equipment.

5. We also note the intention to consider further assessment of competition in some areas using metrics such as share of FTE vets or share of consultation rooms. As part of any further analysis, it may be helpful to consider additional metrics such as:

    - Whether the practice offers small animal services only or whether facilities are shared with farm or equine work. This will impact the amount of FTE vet time spent on small animal.
    - Number of FTE RVNs who will also provide client services and use consultation rooms
    - Number of branches, and whether those feed into a central facility.
    - Provision of referral services (including peripatetic visiting vets), or Out of Hours (OOH) provision for other practices in the area, both of which will use FOP space and resources.

## Out of Hours providers

6. We note the CMA's view that its analysis suggests that the provision of outsourced OOH care is more concentrated than the supply of FOPs, possibly because there is less demand and fewer suppliers which may be because OOH care is typically only accessed in emergencies. The analysis identified 356 providers of outsourced OOH services and, of these, 69 (19%) face no local

[1] https://www.bva.co.uk/media/5766/bva-transparency-and-client-choice-guidance.pdf

competitors and a further 88 (25%) face only one local competitor. In total this represents 44% of OOH sites.

7. As we have previously explained that historically veterinary practices have provided their own OOH cover with all vets employed by the practice on an on-call rota, supported by a locum if needed. In many cases this service was not charged for commercially. Many practices saw it as their duty to provide this service for their clients, as well as an RCVS requirement, and it was delivered at a loss, cross-subsidised from other areas of practice income.

8. OOH veterinary services need a critical mass of work to be commercially viable for the provider of the service. In areas of high human population density, there will be correspondingly more pets, but in many other areas, especially rural or remote areas, there is not enough work to support multiple OOH providers. In recent years there has been a significant shift in the companion animal sector to outsourcing OOH care to providers with a more commercially viable structure that specialise in delivering OOH care, with professional staff specifically employed to work nights and weekends[2] This has gone a long way to supporting a diversity of veterinary practice business models offering daytime care, including smaller independently owned practices. It also supports a better work/life balance for veterinary teams, which ensures that practices can recruit and retain experienced staff, and enables the delivery of good quality veterinary care both day and night.

9. For owners in geographically remote areas of the UK, access to a choice of OOH providers is simply not feasible. For smaller practices, with limited close neighbouring practices with whom OOH cover can be shared, outsourcing OOH to one practice as an OOH provider may be the only way that local FOPs practices can meet the obligation to provide 24/7 emergency first aid and pain relief for all animals, retain staff, and remain viable as businesses. Outsourcing OOH work to dedicated providers also supports the sustainability of the workforce by allowing those vets who cannot or chose not to work on an OOH rota to stay in practice.

10. We therefore support the CMA's assessment that the nature of outsourced OOH means that its provision is likely to be more highly concentrated than for FOPs due to less demand, and that OOH care is also more expensive to provide as it depends on staff working unsocial hours. We agree that it may be the case that concentration is high in a number of local areas, with no likely scope to increase the number of competitors.

11. We would strongly advise against any remedies which shift the requirement to deliver OOH back to individual practices. For many, this would be commercially unviable to deliver due to insufficient demand set against the challenge of modern working practices and recruiting to cover an OOH rota in addition to the normal daytime provision. Any such shift could have serious consequences, in particular for more remote and rural areas of the UK, leading to inability to recruit staff, closures and therefore reduced consumer choice and animal welfare harms.

## Referral centres

12. We note the CMA's view that its analysis suggests that the vast majority (79%) of referral sites may compete with at least five other local suppliers. However, the analysis to date has considered all referral centres as competitors, irrespective of the specific services they offer. As acknowledged, whilst competition within referral practice for some disciplines such as orthopaedic surgery might be good, for other less common specialisms such as ophthalmology, there is unlikely to be much local competition. This is a simply a reflection of veterinary specialism and case load.

13. As we have previously explained, few vets and veterinary practices, if any, can do everything, and ensuring appropriate care for animals often requires referral to specialists. This involves considering

[2] https://www.rcvs.org.uk/news-and-views/publications/the-2019-survey-of-the-veterinary-profession/ (Section 7.6)

the animal's health needs alongside accessibility and convenience for the client. Referrals are also based on close professional relationships between referring and referral clinicians. Over time, these relationships build a deep understanding of skills (for example post graduate RCVS recognised training compared to on-the-job experience), expertise, possible costs, waiting times, type/level of follow up/after care and availability of CPD and telephone support, which in turn builds confidence for the referring vet that they can be confident in their referral. This also means they are better placed to advise clients on what to expect. A referral is not merely a transactional arrangement between service providers.

**14.** The working paper appears to focus on referrals to Specialist vets, as defined by the RCVS, who will have at least a postgraduate diploma level qualification. This view of referrals is far too narrow and fails to recognise that referrals may also be to RCVS Advanced Practitioners, certificate holders, or simply to colleagues within the same practice or externally to another practice who have a particular interest in a particular area of work. We recognise that greater clarity around these qualifications is needed for consumers to fully understand this element of referrals.

**15.** The working paper rightly recognises that since a referral centre that specialises solely in oncology is unlikely to be a substitute for one that specialises solely in orthopaedics, the analysis could differ if each specialism was considered individually. However, we do not consider that the stated intention to potentially carry out further analysis at a specialism level will provide meaningful data. The presence of a specialist is informed by the availability of sufficient caseload. There are some specialisms where there will be competition in many localities – in particular surgical disciplines such as cruciate ligament surgery, fracture repair, and non-urgent cases such as CT imaging – but there will also be numerous situations where it is necessary to phone around for even one option for less common presentations. Where the volume of work is low it simply is not reasonable to expect that there will be more than one referral option in a locality, and in some cases none at all.

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